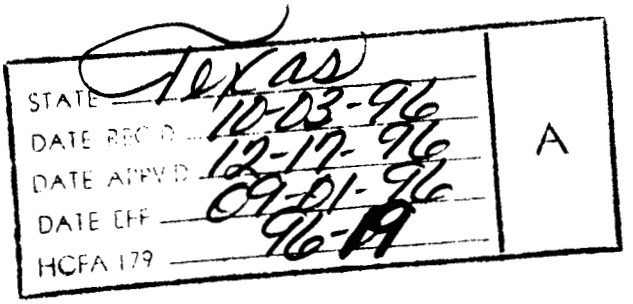
(2) For Priority 1 clients. DHS determines the recommended reimbursement by summing the recommended reimbursement described in paragraph (D) of this subsection for the cost area components described in paragraph (A)(1)and(A)(3)-(5) of this subsection.

(F) The DHS board determines reimbursement after consideration of analysis of financial and statistical information, and the effect of the reimbursement on achievement of program objectives, including economic conditions and budgetary considerations. The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval of Medicaid reimbursements.

VI. Pro forma costing. When historical costs are unavailable, such as in the case of changes in program requirements, reimbursement may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

VII. Adjusting reimbursement. DHS may adjust reimbursement to compensate for anticipated future changes in laws, rules, regulations, policies, guidelines, economic factors, or implementation of federal or state court orders or settlement agreements.



SUPERSEDES: TN • 87-02

15. The State Agency will pay for authorized Day Activities and Health Services provided to an eligible recipient according to provisions of a contract with the provider. Reimbursement will be based upon a cost-related prospective rate.

16. Subject to specifications, conditions, and limitations established by the Single State Agency, payment for ambulatory surgical center facility services will be made on the basis of Medicare established and prospectively determined rates and rules when such services are provided in connection with approved surgical procedures performed in ambulatory surgical center facilities participating in the Medicare Program and in the Texas Medical Assistance Program under this Title XIX State Plan, unless otherwise specified by the Single State Agency. Payment for other services which are covered under the Title XIX State Plan and which are apart from and other than ambulatory surgical center facility services will be made under other provisions of this State Plan, as appropriate to the provider performing the service.

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17. Nurse-Midwife Services

Subject to specifications, conditions and limitations established by the State Agency, payment for covered Nurse-Midwife Services provided to eligible recipients by a participating, approved Certified Nurse-Midwife (CNM) is limited to the lesser of the actual charge or 85% of the rate reimbursed to a physician for the same service except that payment is made at the same level as physicians for laboratory services, x-ray services, injections, and family planning contraceptive devices, drugs and supplies.

Payment for covered CNM services will only be made to the CNM who actually performed or directed the service(s) in accordance with federal regulations, unless federal requirements related to reassignment of claims have been met. CNMs who manage the medical aspects of a case under the control and supervision of a physician in accordance with the rules of the State Board of Nurse Examiners and the Medical Practice Act will only be reimbursed by the Texas Medical Assistance Program for such services to the extent that they are performed under the written protocols required by the Board of Nurse Examiners and are not duplicative of other charges to the Medicaid Program.

A CNM will not be reimbursed directly by the Texas Medical Assistance Program for services provided if employed, salaried or reimbursed by a hospital, birthing center, other institution, or facility where the CNM's remuneration for services is included in the reimbursement formula or vendor payment to the hospital, facility, in-stitution, or other provider.

CNMs who are employed by, or remunerated by a physician, health maintenance organization, hospital or other facility may not bill the Texas Medical Assistance Program directly for their services when such billing would result in duplicate payment for the same services. If the services are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the physician, hospital or other provider, if approved for participation, who employs or reimburses the CNM. The basis and amount of reimbursement will depend upon the services actually provided, who provided the services, and the reimbursement methodology or basis of reimbursement utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.

Payment for services which are other than "Certified Nurse-Midwife Services" shall be governed by the applicable requirements and provisions of the Texas Medical Assistance Program.

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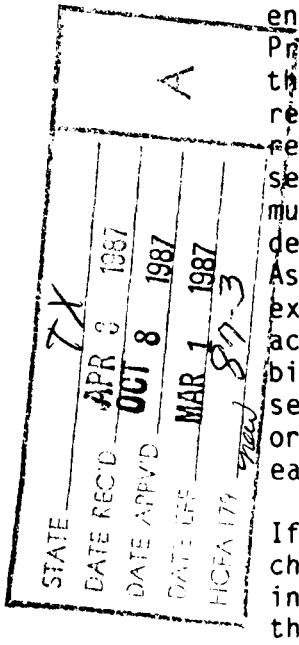
State of Texas Attachment 4.19-B

18. Birthing Center Facility Services

Subject to the specifications, conditions and limitations established by the State Agency, payment for covered birthing center facility services provided by an enrolled and approved birthing center (Category A birthing center) will be limited to the lesser of the customary charge or the maximum allowable fee(s), rate(s) or reimbursement schedule, if any, established by the State Agency or its designee. The State Agency or its designee uses actual charge data obtained from licensed Category A birthing centers in establishing its payment rates. The rates are compared to rates paid for the same or similar services (similar in intensity and consumption of resources) in an inpatient hospital setting or ambulatory surgical center to ensure that the rates do not exceed the reimbursement level for the same or similar services in those settings.

The birth attendant must be a physician or Certified Nurse-Midwife (CNM). The physician or CNM who was the birth attendant must be identified on the birthing center's claim. Prenatal, labor, delivery and postpartum services performed or provided by physicians or CNMs are not considered to be or covered as birthing center facility services. For services other than covered birthing center facility services, other applicable requirements and provisions of the Texas Medical Assistance Program shall govern.

The birthing center actually providing covered center services must bill for the services that it provides. Unless approved by the State Agency or its designee, the birthing center may not bill for services provided by another type of provider. All providers involved must be enrolled and approved for participation in the Texas Medical Assistance Program at the time the services are provided. The birthing center and the other type of provider must ensure that federal requirements related to reassignment of claims are met and that the billing does not result in duplicative or excessive charges or payments for the same services. The provider that actually performed the covered services must be identified on the claim. The basis and amount of reimbursement depends upon the reimbursement methodology used by the Texas Medical Assistance Program for the services and provider(s) involved and cannot exceed the amount that would have been paid to the provider that actually performed or provided the service(s). If the birthing center bills a single or itemized combined rate, charge, or amount for covered services for two or more providers, payment is the lesser of the single or itemized combined charge or the amount that would have been paid had each performing provider billed separately.



If a birthing center utilizes or refers the pregnant woman, mother or child to a CNM, physician, and/or a hospital who does not participate in the Texas Medical Assistance Program or who has not agreed to bill the Medicaid program for services provided, the birthing center, must, in advance, inform recipients of their potential financial responsibility in accordance with requirements of the Texas Medical Assistance Program applicable to all Medicaid providers.

19. Hospice Care.

The TDHS Medicaid Hospice Program pays Medicaid hospice rates that are calculated by using the Medicare hospice methodology, but adjusted to disregard cost offsets allowed for Medicare deductible/coinsurance amounts. TDHS does not apply/follow Medicare hospice rate freezes. The TDHS Medicaid Program also pays physician reimbursements for the physician's professional, direct, patient care services related to the recipient's terminal condition. Physician reimbursements are made according to usual Medicaid payment amounts for physician services under the Texas Medical Assistance Program. No cost sharing may be imposed for hospice services rendered to Medicaid recipients. TDHS uses the current Medicaid reimbursement cap (a maximum) per year (November 1 through October 31) for the Hospice Program.

TDHS pays an additional rate to take into account the room and board furnished by the facility for Medicaid hospice recipients residing in nursing facilities. TDHS pays the Medicaid hospice provider which, in turn, pays the nursing facility. To be paid, the hospice provider and the nursing facility must have a contract that includes the following agreements.

(1) The hospice is fully responsible for the professional management of the recipient's hospice care; and

(2) The nursing facility agrees to provide room and board to the Medicaid hospice recipient.

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Supersedes - TN 90-47

For recipients eligible for both Medicaid and Medicare (dually eligible recipients) who elect the Medicare and Medicaid hospice programs, the Texas Medicaid Hospice Program pays the hospice provider:

(1) a Medicare coinsurance of 5% (not to exceed $5 per prescription) of the cost of drugs and biologicals determined according to a drug copayment schedule established by the hospice;

(2) a Medicare coinsurance of 5% for each day of respite care (not to exceed the inpatient hospital deductible that applies to the year in which the coinsurance period began); and

(3) an additional rate to take into account the room and board furnished by the facility for each day a dually eligible recipient resides in a nursing facility.

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TDHS pays a Medicaid hospice room and board per diem amount, effective April 1, 1990, that is 95% of the appropriate Texas Index for Level of Effort (TILE) rate for each Medicaid recipient residing in nursing facilities, as required by the Omnibus Budget Reconciliation Act (OBRA) of 1989. OBRA of 1989 amended Section 1902 (a)(13)(D) of the Social Security Act to require Medicaid to pay a per diem amount that takes "into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the State under the (State) Plan for (nursing) facility services in that facility for that individual."

TDHS pays the Medicaid hospice room and board rate to Medicaid hospice providers, who in turn pay nursing facilities at least that same amount for room and board services provided to Medicaid hospice recipients residing in that facility.

The TILE per diem rates are determined in accordance with the Medicaid State Plan reimbursement methodology for nursing facilities.

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~~19~~. Maternity Clinic Services

Subject to the specifications, conditions, limitations and requirements established by the single state agency, payment for covered maternity clinic services provided by a participating maternity clinic to eligible recipients is limited to the lesser of the customary charge or the maximum allowable fee(s), rate(s) or reimbursement schedule, if any, established by the single state agency.

Covered services provided by the physician(s) affiliated with the clinic are considered part of the clinic's services and are not reimbursable separately.

If the maternity clinic uses or refers an eligible patient to a physician, certified nurse-midwife, hospital or other provider of services that does not participate in the Texas Medical Assistance Program, the maternity clinic must inform the patient in advance of the patient's potential financial responsibility according to the requirements of the Texas Medical Assistance Program.

21. Case Management for persons with chronic mental illness.

Reimbursement for case management services for individuals with chronic mental illness is subject to the specifications, conditions, and limitations required by the operating agency or its designee. These include the specifications provided in OMB Circular A-87 and A-102.

The statewide reimbursement rates for this case management services program are interim throughout the rate period and subsequently adjusted to cost. The operating agency or its designee determines statewide reimbursement rates at least annually, but may determine them more often if deemed necessary. The reimbursement rates are based upon allowable costs, as specified by the operating agency or its designee, for qualified staff, travel, facility, and administrative overhead expenditures. The unit of service is one face- to-face contact per month.

Claims for reimbursement for case management services include:

- date of service;
- name of recipient;
- identifying Medicaid number;
- address
- name of provider agency;
- unit(s) of service delivered; and
- place of service.

Reimbursement rates are determined in the following manner:

1. Inclusion of certain reported expenses. Provider agencies must ensure that all requested costs are included in the cost report for administrative claiming. All references to cost reports are the cost reporting process for administrative claiming. Failure to do so may result in penalties.
2. Several different kinds of data are collected. These include the number of units of service. The cost data include direct costs, programmatic indirect costs, and general and administrative overhead costs.

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SUPERSEDES: TN - 88-23

a. Case management is an activity performed by a qualified case manager employed by the provider agency, with the person served to assess needs, and locate, coordinate and monitor necessary services. Separate rates are set for services provided to individuals in the adult mental health priority population and individuals in the child mental health priority population.

b. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this case management program that are indirectly related to the delivery of case management services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the case management services program, constitute costs that support the operations of the case management services program. Providers must eliminate unallowable expenses from the cost report. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for provision of covered case management services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the database.

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SUPERSEDES: NONE (NEW PAGE)